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IS it for "sweet charity's sake" or simply to make a good showing at the end of the year, that so many patients are treated at the dispensaries that can afford to pay? If for charity, then they are misdirecting their efforts sadly—for the encouragement of charity-seeking is a most pernicious evil, that should be discouraged in every possible way.

It is well that Homœopathic Dispensaries should have a good showing in the number of patients they treat, but it is better that they have a record that they treat only such patients as are deserving.

Physicians who prescribe medicines for this class of patients in a dispensary established and endowed "for the treatment of the sick poor who are unable to pay for medical advice," are misusing, to put it mildly, the funds of the institution. They should remember that they are here to treat a certain and specified class of patients, and as soon as they depart from that

rule they are acting outside the laws of the institution in which they are practicing.

There is now a movement on foot in this city to establish thirty-four new dispensaries—old school—where a small fee will be charged for all medicines and advice. We do not see the object of these new affairs, though it is stated to be the treatment of the working class who are unable to pay and are too proud to accept charity. That seems very nice; but about once in a lifetime only is it you hear of a physician refusing to treat a patient who is unable to pay his regular rates. And as to the pride of this class, it is usually the other way—they are too proud to pay at all. We do not think they will last very long; these self-styled philanthropists will find out that they have mistaken the feeling among the classes who patronize dispensaries. We do not believe there is a practicing physician in this city but who has on his visiting list a free list of worthy poor, that he treats free or for a nominal sum, and these patients would not go to a dispensary, no matter how small the sum charged. These new dispensaries are to be painted green, so the information runs. The board who has the matter in charge will probably think of this in a few months—and paint themselves.

Allopathic Remarks with Homœopathic Reflections

IN Ziemssen and Zenker's *Deutschers Archiv für Klinische Medizin* (Allopathic) (41. Bd. 1. and 2. H.) we find an article by Dr. Gläser of Hamburg: "On the conditions of the temperature in 200 cases of typhoid, terminating fatally, with some heretical remarks on Antipyresis," which is of some interest to homœopaths.

After having given with admirable exactness the degrees of temperature, rates of pulse, re-

sults of post-mortem examinations and contrarious opinions of prominent authorities, he passes on to *Antipyresis* and writes as follows:

"The greatest difficulty in estimating the influence of remedies in diseases would seem to lie in the fact, that the majority of physicians are unable or not inclined to *imagine the diseases uninfluenced by medicines*. The natural desire to help the patient rarely allows us to observe pathological conditions without therapeutical interference. Even in conditions with which we are unacquainted, we will rather interfere empirically than allow the disease to take its natural course. From this it follows that our *knowledge of the uninfluenced course of disease is comparatively meagre*.

"But in a certain measure this knowledge has been furthered by the *Austrian school* and by *homœopathy*. The former proved that certain diseases, entirely uninfluenced, terminate *at least as favorably, if not more so, than had they been bothered by the ordinary attempts at healing*. *Homœopathy*—although quite unintentionally—proves the same, for we—the allopathic majority—from our knowledge of drug-action, count its *therapeutic interference nought*."

And later on he writes:

"Yet one should easily come to the conclusion that the *diseases*, especially the epidemics, are *not markedly influenced* by our therapeutic measures—(excepting, of course, the hygienic ones, as cleanliness, food, etc.)—if one reviews the *legion of remedies* which, after a short period of fame, are *relegated to eternal oblivion*.

"For me, the *elevations of the temperature* have only the meaning of the *barometer* which announces the *storm*. No more than I consider it as the cause of the storm, do I regard the *higher temperature* as the cause of aggravation of the disease; and I would consider it just as rational to *break the barometer* in order to quiet the storm, as it would be to *attack the temperature* with the intention of *vanquishing the disease*. If in any case it would seem that this result has been obtained by *antipyretic* means, the *cause of the disease* has been struck unintentionally and not only the high temperature. This result, however, is not as likely to be obtained as

is another one, namely, that by measures against the fever the general picture of the disease becomes distorted, and that the physician thus loses a valuable guide for his measures."—(Dr. Proell, *Allg. Hom. Zeit'g.* Bd. 115. No. 18.)

C. S.

Notes of a Lecture on Mercury.

BY PROF. T. F. ALLEN.

THIS drug has been used by physicians for many generations, and its effects in disease are well understood. Its effects upon healthy beings are perfectly well known, for there are thousands of cases of poisoning among workers in mines of quicksilver or cinnabar, and in various manufactories where mercury is used, etc., and there is no difficulty in placing before you a complete picture of the action of this drug.

One of the first observed effects is the increased secretion of saliva. This stimulation of the salivary glands co-exists with soreness of the gums and mouth, with swelling of the glands, and when this condition persists for a long time, ulceration of the gums, mouth and cheek take place and inflammatory processes seize on the roots of the teeth. When patients were given large doses of mercury in former times, they were enjoined not to take water, since the chilling of the gums and mouth by cold water increased in a very marked degree the destructive action of mercury, so that, as this drug was used almost universally in the treatment of acute febrile disorders, the poor patients were not allowed the use of water. The destructive action of mercury upon the mouth and the ulceration of the gums, tongue and cheek, the formation of pus at the roots of the teeth, the increase of saliva, may in some cases co-exist with dryness of the general buccalmucous membrane, but, as a rule, the secretions from the mucous membrane generally are increased. This is undoubtedly true of most secretions, certainly those from glandular structures and from the skin.

Throughout the whole digestive tract the mucous membrane becomes affected with

catarrhal inflammation, gastro-enteritis results, with inflammatory symptoms extending from the lips to the anus. Diarrhœa of course ensues, associated with colic and especially with tenesmus. In older cases hemorrhages result, due to the ulcerative processes. When the inflammation is violent and affects the lower portion of the intestinal tract, the symptoms are those of dysentery, the bloody stools being accompanied by a high degree of inflammation, secretion of mucus and with great straining.

The different preparations of mercury vary very much in intensity and to some extent in the character of the symptoms of inflammation of the gastro-intestinal mucous membrane. Calomel seems to act more upon the upper part of the intestinal tract, causing diarrhœa with much green mucus and with very little straining, while corrosive sublimate acts more upon the lower part of the intestinal tract, and the symptoms are more those of acute dysentery.

Of the general actions of mercury on other organs, we direct your attention next to that of the kidneys, in which mercury produces a true parenchymatous inflammation. Frequently the interstitial tissue of the kidney becomes involved, and chronic interstitial nephritis results. As a matter of course we find the urine bloody and albuminous, with casts marking the various stages of inflammation.

It produces inflammation of the liver and decreases the secretion of bile, and it seems probable that the old idea that mercury was a particularly good medicine for the liver was based upon its power to produce secretions of gastro-intestinal mucus, the increased irritability of the intestines and peristaltic action undoubtedly removing from the body a portion of the bile which would otherwise have been absorbed into the portal circulation, for this is certain, that after the first effects of mercury the bile becomes largely diminished and may even cease to be excreted, or at least to be poured into the intestine. The curative power of mercury over the liver which does not secrete the proper amount of bile, whether from the intestinal inflammation or the occlusion of the common bile duct, is undoubted. In both these cases

mercury acts homœopathically, and there is no doubt that its wide reputation at present, and especially in the past, is directly due to this homœopathicity, though its employment has been terribly abused.

In respiratory tract generally we find diffuse catarrhal inflammation with increased secretions of mucus. It certainly causes a high degree of bronchitis, which may often increase to a form of pneumonia, a pneumonia with a loose flocculent infiltration.

One of the most common and characteristic effects of mercury in a general way, is its ability to produce profuse perspirations. All the mercury patients perspire easily without provocation or on the slightest efforts. Indeed, persistent dryness of the skin is sufficient to contra-indicate mercury.

On the tissues generally, this powerful drug exerts the most destructive influence. It destroys the power of the system to repair lesion, so that cuts will not heal nor broken bones unite. In the bones it certainly produces inflammation of the periosteum, which will lead on to destructive metamorphosis and death of the bone.

One of the most singular phenomena in the whole range of drug action is exhibited in the power of mercury to produce tremors. Its action on the nervous system is one of the curiosities of mercury. It has been noticed by observers that among workers in mines and in factories under the influence of fumes of mercury a certain proportion are attacked by mercurial tremors, and are to a great extent or entirely free from the tissue changes from which the others suffer. These tremors usually affect the muscles which are under the control of the will. These muscles respond to electrical action and are variously affected. The spasms are chorea-like in nature, and small objects held in the hand, for example, will be thrown violently across the room in the effort to carry anything to the mouth or to lay it upon the table. The muscles will not respond to the will. Sometimes the tremors are so violent that the patients cannot lie in bed, the jerks will throw them out of bed, or throw them down

when attempting to walk. With all these nervous disorders the patient enjoys the most perfect consciousness. Some of these tremors are wonderfully like paralysis-agitans, but yet they are different, at least, I have never been able to cure a case of paralysis-agitans by the use of any preparation of mercury, nor indeed do I remember ever succeeding with mercury in a case of chorea. These tremors are *sui generis*, and it is very doubtful if we meet with a similar condition in any natural disease.

Before proceeding to an analysis of symptoms obtained by provers, we must speak of another action of mercury, and that is, its supposed power to prevent the development of pathogenic organisms. I presume there is no doubt but that if the system be thoroughly saturated with mercury, low forms of life will not develop. We know that a solution of corrosive sublimate more dilute than one part to four thousand, will destroy or prevent the development of organic life. It is probably true that many of these organisms develop in the body in a manner similar to the growth of the yeast plant. They derive their sustenance from the fluids in the body, and develop chemical substances which, in some instances at least, seem to be peculiarly poisonous. If the blood can be saturated with mercury in the proportion of one part to five thousand, or even less, the development of these germs will probably be arrested. While this saturation of the system is practically impossible, yet it seems that mercury, in a much more dilute form, has a specific power to prevent the development of certain germs, if not of all germs.

Now, without entering farther into the discussion of this subject, I wish to call your attention to the remarkable fact, that among the thousands and thousands of persons who have worked in mines and factories, and have been poisoned by mercury, until their bones have decayed, no case of syphilis is known, and these people are not at all particular about their associations, and are much more inclined to sexuality than others, because mercury positively excites the sexual desire. These people cohabit with the vilest of the vile, and the knowledge is wide-spread among them that they are proof against syphilis. If we ex-

amine into the matter we find the following interesting facts: That syphilis attacks different bones from mercury; that mercury attacks bones and joints that are rarely or never attacked by syphilis. Among a large number of workers suffering from caries, there was not a case of caries of the skull, tibia, clavicle or sternum, the bones which are particularly affected by syphilis. Looking for a moment at syphilis, we find that one of the most characteristic symptoms, one that is the most sure to occur is iritis, and we find that among all the thousands of cases recorded of mercurial poisoning, there is not a case of iritis. Moreover, there has never been known an instance of ulcer of the glans penis among the cases of mercurial poisoning, nor has mercury ever produced any ulcer with indurated edges. It does not produce an eruption like that of syphilis; indeed, it may be said that among the provings and poisonings there is scarcely a symptom of syphilis. It does not produce the hypochondria of syphilis.

How, then, are we to explain the destructive power of mercury over syphilis? We can explain it no more than we can explain the protective power of quinine over malaria. If, however, the patient be once attacked by syphilis, mercury will not antidote or remove it any more than quinine will remove marsh malaria, indeed not as much. Mercury more thoroughly protects the system against syphilis and more completely fails to cure it than quinine in marsh malaria. Some of the most pitiable cases seen in our hospital, are those who have first become afflicted with syphilis and then become saturated with mercury; the bones that syphilis did not destroy are destroyed by mercury, the tissues not affected by syphilis are affected by mercury, and his last end is worse than his former.

But parenthetically, syphilis is curable homœopathically. It must be treated in its early stages by nitric acid, by iodide, by the bichromate of potash; its iritis by bryonia, by iodide and by aurum; its latter destructive elements opposed by aurum, by platinum, by the potashes, etc., etc., but I think, not by mercury.

Speaking of iritis, I must say that I do not now remember a single case of iritis in all my ex-

perience presenting symptoms or being benefited by any preparation of mercury that did not contain iodine. These cases are best treated by bryonia, iodine, aurum or such drugs, not by mercury.

In my limited experience I have treated a few cases of syphilis from the very beginning and have seen the different stages in a mild form growing more and more slight, until, after two or three years, all vestiges of the disease have disappeared, and I would not fear the results of pure homœopathic treatment in large syphilitic hospitals; certainly they would not suffer by comparison with the present methods.

After these preliminary remarks of a general nature we will proceed to a more careful analysis of the symptoms which are the indications for the use of mercury in disease.

A Lecture on the Mechanism of Labor in Face Presentations.

BY PROF. L. L. DANFORTH.

GENTLEMEN: The mechanism of labor in face presentation has great analogy to that in the vertex presentation, and should therefore be considered in close relation with it.

Presentations of the face, as we stated in our last lecture, are included in the category of *natural* labors, because they are capable of being terminated by the *natural* forces; they cannot, however, be regarded as strictly normal, as they do not realize the mechanical conditions compatible with the highest degree of safety to both mother and child.

Face presentations are fortunately rare. You may practice midwifery a great many years, and not meet with a case of this kind, and yet the conditions which cause them are such, that one of the first cases you will be called upon to attend may be of this variety. The frequency is variously estimated as 1 in 231 (by Churchill, out of 250,000 cases collected, or by Spiegelberg, from German Statistics, as 1 in 324).

As compared with breech presentations, there are five of the latter to one of the face, while presentations of the brow are very much less frequent than those of the face—as 1 in 6 or 7.

In *face presentation*, the head, instead of being flexed upon the sternum, is extended, so that the occiput is reflected upon the back, and the face and forehead form the presenting part.

Causation. What are the influences which tend to produce this position of the head? There are several:

First.—A peculiar shape of the child's head, in which the occiput projects more than usual. This is a cause which has been considered by Hecker to be quite important. You can readily see that a head-bone, with the face first, would be considerably elongated in its antero-posterior diameter, as well as flattened in its vertical diameter (cervico-bregmatic). In a few cases, this peculiar shape (dolicho-cephalic, it is called) does persist after delivery, and when it does so, may justly be assumed to be the cause of the face presentation, the latter being produced by the catching of the prominent occiput upon the brim of the pelvis. As a result, first the forehead, then the face, and lastly the chin, enter and descend into the pelvic cavity, the uterine forces and the resistances uniting to intensify the abnormal presentation.

Second.—Disproportion between the head and pelvis, with consequent detention of head above brim, is apt to produce face presentation. The generally contracted pelvis will do this. The head is caught at the ends of the biparietal diameter, instead of at the ends of the long antero-posterior diameter. Here the occiput, being more resisted than the front part of the head, the uterine forces are excited posterior to the condyles (the point of articulation of the spinal column with the head), instead of in front of them, and then more or less extension will be produced.

Third.—Any accidental cause, like a sudden gush of liquor amnii, may effect a presentation of the face by producing a partial extension of the head, which the resistances soon complete. This is more likely to occur with a premature or dead child.

Fourth.—An unnatural degree of *anterior obliquity* of the uterus is a cause which may exist alone, or may be combined with any of the others. This condition is most frequently met

with in multiparæ, with lax pendulous abdominal walls. The child lies well forward, with its dorsal surface in contact with the convex anterior uterine wall. The propelling force, acting through the spinal column, posterior to the axis of the pelvic inlet, tends to push the condyles towards the long arm of the head lever (the chin end of the head), while the short arm of the lever (the occipital end of the head) remains unaffected in contact with the convex anterior uterine surface. The resistances, therefore, produce progressive extension instead of flexion, the resistance to the forehead having the mechanical advantage over that to the chin, until the chin becomes the most advanced point, and extension is at last checked by the occiput being compressed against the neck.

Varieties of Face Presentation.—In face as in vertex presentations, there are four positions, each of which is developed out of the corresponding position of the vertex. It is customary to define the position of the face, with reference to the location of the chin, in one or other of the four quadrants of the pelvic inlet. Thus we have the first position, with the face lying in the right oblique diameter of the pelvic inlet, the forehead opposite the left obturator foramen, while the chin is opposite the left sacroiliac synchondrosis. The head may lie in a position midway between the oblique or transverse diameter, or quite transversely. The reason that the chin instead of the forehead is selected as the part which gives to the position its name, is that the chin descends first in face presentations, as the occiput does in vertex presentations. The chin, therefore, in these cases, is the mechanical equivalent of the occiput in vertex presentations.

The four following are the positions of the face:

First.—The chin points to the right sacroiliac synchondrosis, and the forehead to the left foramen ovale, while the median line of the face crosses the os uteri in the same manner as the sagittal suture does in the corresponding cranial position.

Second.—Chin to the left posterior part of the pelvis, forehead right anterior, opposite right foramen ovale.

Third.—Chin left anterior, forehead right posterior. The median line of the face is in right oblique diameter of pelvis, as in the first position, but chin and forehead have changed places.

Fourth.—Chin right anterior, forehead right posterior.

We will commence with the study of the mechanism in the *first or right mento-posterior position*, as this is the most frequent, although it does not preponderate over the others, as does the first vertex over the other vertex presentations. In order to understand the movement which the head undergoes in its advance into the cavity of the pelvis, we must bear in mind the action of the forces involved. Not to take up too much time in the study of this subject, I will simply say, that the dynamics ruling in vertex presentations, rule here. These we have carefully studied. They are briefly:

First.—The driving forces (the uterus) acting upon the head through the atlanto-occipital articulation.

Second.—The depression of the long, mental end of the cranial lever, and in other words the extension of the chin. This is due to the force of the resistance met with by the short or frontal end of the cranial lever arm. The condition which prevented the descent of the occiput, and the production of an ordinary vertex presentation, persists in preventing the descent of the forehead. The resistance is greatest on the forehead or occipital end of the lever arm, hence transference of the force to the posterior or mental end of the lever arm, and increased *extension* of chin away from sternum, and *descent*. In other words, that portion of the head descends to which least resistance is opposed. These are the two movements, then, which the head first undergoes.

Extension and descent.

The former is limited to the length of the neck from chin to sternum, and the latter to the resistance which the chin meets with by the soft parts in the posterior parts of the sacral hollow. The chin represents the apex of the wedge, while the head and the neck represent the base. As the base tries to engage in the pelvic brim, the

occiput is driven into the back, the cranial vault is flattened, the chest is lessened in its antero-posterior diameter; and thus the base of the wedge may be so far moulded that it can descend some way into the cavity. When it has descended as far as the length of the neck will permit, the next step in the progress of the delivery is the movement of *rotation*. The chin, under the influence of continued driving force, is opposed by the resisting inclined plane of the pelvic floor, and in *obedience* to a general rule, which is, that the pole of the head occupying the lowest place in the pelvic cavity will travel toward the pelvic symphysis, proceeds to move upward and forward along the right side of the pelvis, until finally it is liberated under the arch of the pubis. This is *rotation*. The median line of the face is not exactly in the antero-posterior of the outlet. The chin is under the right branch of the pubic arch, the face during the whole process preserving a strictly oblique position, both as to the transverse diameter and the axis of the pelvis. By this manœuvre space is gained in the posterior part of the pelvis and the occiput descends. The driving force can no longer affect the chin end of the head. The force is therefore transferred to the occipital end, the latter descends, and a movement of *flexion* results. The wedge spoken of in the beginning is decomposed—broken up—and the whole head revolves around the chin as the pivotal point underneath the symphysis pubis.

It will be noticed that this movement of *flexion* is just the reverse of the first movement described, viz.: *extension*, and that these two movements, in the order of their occurrence in face presentations, are the reverse of their order in vertex presentations. The completion of flexion, brings successively the entire lower part of the face, then the upper part, the forehead, the bregma, vertex, and finally the occiput, into the world, the head is born.

The *second* position of the face is merely the reverse of the first.

The *third* and *fourth*, or mento-anterior are comparatively simple. The chin is already nearer the pubic arch, and has consequently a much shorter distance to travel in its rotation

towards liberation than in mento-posterior positions. The principles of the mechanism are the same as already described and need not be repeated.

The mechanism of unreduced mento-posterior positions, and the management of face presentations generally, will be reserved for a subsequent lecture.*

Surgical Clinic at the Homœopathic Hospital on Ward's Island.

OPERATION FOR LARGE MYO-FIBROMA OF THE UTERUS, BY PROF. WM. TOD HELMUTH.

REPORTED BY F. B. KELLOGG, M. D., HOUSE SURGEON.

A LARGE audience, composed mainly of the Senior class, assembled at the Ward's Island Hospital, to witness this important operation; the different steps made plainly visible by the large calcium light managed by Frank.

The patient, E. A. S. (colored), was admitted to the hospital November 1, 1887, aged thirty-eight; single; occupation, housemaid and waitress. Family history excellent, no hereditary disease, but her aunts on her father's side were said to have uterine tumors. Her sister also has a small one; patient never had any serious illness excepting attacks of profuse flooding, corresponding in time to a menstrual epoch, and separated from each other by intervals of about a year—the last having occurred about a year ago. Her menses had been regular in time, though scanty, being usually preceded by and attended with some diarrhœa.

About five years ago she suffered from a copious discharge of dark, bloody and serous matter from the uterus, and noticed at the same time a marked diminution in the size of the tumor (a phenomenon difficult to explain in the light of the subsequently disclosed character of the growth). The appreciable existence of the tumor dated back ten years, although for three

* These lectures are illustrated with an infant cadavert, in a Budin Manikin.

years previous to this she was subject to symptoms pointing to growth in and about the uterus, viz. : pain in the back, bearing down, and looseness of the bowels before and during a menstrual epoch.

For the last five years the growth had been rapid, until, at the time of examination, it presented the appearance of a pregnant uterus at full term.

It was symmetrically spherical, except for a slight inclination to the left, and apparently perfectly solid, the deepest pressure yielding no fluctuation. The upper boundary of the tumor was clearly felt crossing the abdomen in the epigastric region, and it was noticed that there was another area of dense induration, roughly rectangular in shape and about three inches by six in size, lying on the left, between the tumor and costal cartilages. This was assumed to be the liver, although it was situated too low down for that organ in a normal condition. A normal liver would have been displaced upward, if affected at all, and it was necessary to assume passive congestion and enlargement from pressure, in order to explain the anomaly. The *morale* of the patient, as the time for the operation approached, was excellent. Her appetite had always been generous and her bowels regular; and the only features of the case which were discouraging were her extremely emaciated condition and night sweats—to which she had been subject for some months—and the character of the tumor.

A urinary examination disclosed about $\frac{1}{10}$ of 1% of albumen, which was easily explained by the pressure of the tumor. She was given a saline cathartic, the night before the operation, and her urine was voided just previous to giving the ether.

The anæsthetic was administered to the patient in her own room, and she was carried into the Amphitheatre when the operation was performed. The abdomen was washed with soap and water, and an ethereal solution of Iodiform poured over it. Rubber cloths were folded to protect the parts above and below the point of operation, and the preliminary incision made about eight inches in length in the median line.

The stretched and thin abdominal walls parted, disclosing the tumor, an immense fibroid. It was everywhere adherent to the abdominal walls, and in breaking up these adhesions several large veins, with which the surface of the tumor was covered, were unavoidably ruptured, giving rise to very profuse hemorrhage. At every step new vessels were broken, until it became inexpedient to stop and tie them. Everything was then sacrificed to speed. Hot sponges were placed upon the bleeding points as fast as they appeared, while Dr. Helmuth extended the first incision upward about two and one-half inches, and made another at right angles to the first from its central point, cutting through the right rectus muscle for about three inches.

With this additional working room the tumor was enucleated from its bed and rolled forward; two long pins (Wilcox pins) were thrust through the pedicle, and a ligature consisting of three elastic rubber strings, about twice the size of an ordinary shoestring, was strongly stretched and wound about it beneath the pins. This instantly stopped all hemorrhage and the pedicle was then amputated above the pins. Flannels wrung out in hot water were kept packed in the abdominal cavity during the manipulation of the tumor and pedicle.

A remarkable feature after removing the tumor was the apparent absence of the intestine. Not a sign of one was seen during the operation. Above and to the right, within the cavity, was a prominent body imbedded in fibrous tissue, which was supposed to be the liver, while on the left was another smaller one which was taken for the spleen. After ligating all the bleeding points within the cavity a catheter was passed to make sure the bladder was not included with the pedicle in the ligature, and the abdominal wound was brought together with silver wire sutures, leaving the pedicle on the outside. The dressings were applied and the patient hurried into a warm bed.

An hour after the operation her pulse was seventy-eight and temperature normal. She suffered little from vomiting. During the five and one-half days following the operation there was great restlessness, and it was impossible to

keep her in one position. She complained greatly of pain in her back. Only on the second day did she complain of soreness in the abdomen. She took her teaspoonful of rice-water every two hours, and, after two days, this was replaced with malted milk. When thirsty she was given a piece of cracked ice. After the third day she began to have loose stools with some terseness. The catheter was passed at intervals from the first. Every successive day found the temperature one degree higher, and the pulse correspondingly more rapid. The diarrhoea increased toward the last and stools were passed involuntarily. The temperature at the end of the fifth day registered $104^{\circ}.5$, pulse uncountable, and she died at eight in the morning.

On post-mortem, the bodies which had passed for liver and spleen were found to be fibroids similar to the one removed. Eight others of smaller size were found completely covering in the intestines, and the uterus itself was enlarged to the size of a base-ball with another. Total weight fifteen pounds. The abdominal wound had healed almost throughout by first intention, and the rubber ligature had nearly severed the connection between the external and internal portions of the pedicle, about the thickness of the little finger remaining.

Operation at the Laura Franklin Hospital

ON Thursday, Nov. 24th (Thanksgiving day), seven members of the graduating class were fortunate enough to witness an operation for ex-section of the lower end of tibia, by Dr. F. S. Fulton, at the Laura Franklin Hospital.

Patient, Arthur —, aged ten years, was admitted to the Hospital on November 18, 1887. The disease was the result of an injury. Dr. Fulton kindly explained the different diseased conditions which might necessitate operations upon bones in their continuity.

Caries, which affected only a limited portion of bone, and was superficial, might demand removal by scraping or by dissection.

Necrosis, in which a large part of the bone

became dead, and which might affect any portion of the bone, either external or internal, might require either sequestrotomy—if a sequestrum were formed—or resection, if it involved the entire diameter of the bone.

Osteo-myelites, in which the entire bone became diseased, and ultimately dead, from central inflammation, would necessitate its removal in mass, or central abscess of bone, most frequently found in the tibia. This should be opened by the gouge and chisel, the dead bone removed, and the wound treated as an abscess in soft parts. In abscess, and when a sequestrum was formed, a large amount of new bone was apt to be deposited on the diseased portion, constituting an involucrum, through which orifices or cloacæ lead to the affected part. In order to ascertain if a sequestrum were formed, the probe or director must be used, and sufficient pressure made upon the dead portion to determine if it were present, and loosened from the surrounding portion. If the sequestrum were loose, it would be the exact moment for operation. Or if an abscess cavity could be diagnosed, it should be operated on at once.

In this case a large involucrum was present, and dead bone tissue was easily detected inside, but no sequestrum could be found.

Great difficulty was experienced in anæsthetizing the patient. The parts were then thoroughly scrubbed and shaved, and a heavy Esmarch's bandage applied. Then by making a free longitudinal incision, dissecting the tendons out carefully, cutting through the periostum, which was much thickened, Dr. Fulton exposed the involucrum and cloacæ. After pushing up the periosteum with an elevator—with a small chisel—he cut through and removed a portion of the involucrum. With a gouge, cut and scraped out the necrosed bone within the cavity, removing quite a large quantity, and cleaning away to healthy bone tissue.

No sequestrum was found. The trouble was evidently a central abscess of the lower extremity of the tibia.

During the operation, frequent douches of Hg. Cl² Sol. 1-2000, were made, and the cavity of the wound was thoroughly washed out with

the same solution, after having been relieved of the dead tissue. The rubber bandage was then removed, and the circulation re-established; no arterial branches had been injured. After introducing two sutures in upper part of the wound, it was well dusted with Iodoform powder, and lint packed with marine lint. A wad of borated cotton was placed over this, then the thin rubber dressing, and a roller Hg. Cl² lint bandage was applied to hold the dressing in place. The dressing was to be removed the next day, the wound cleansed, then packed for awhile, in this way gradually allowing the formation of new bone until completed, when the external wound will be allowed to heal. The operation was comparatively bloodless.

W. A. W.

Going into a "Decline."

I AM strongly of the opinion that the decline of homœopathy and other "isms" in the profession, which is now well under way, is largely due to the dignified ignoring of them on the part of the regular profession during these latter years.—*Dr. I. N. Love, in The Medical Register.*

When our brethren of the opposite school talk so learnedly of the "decline" of homœopathy, why don't they publish some statistics showing their readers a few facts? For instance, the relative percentage of cures in the Middletown Insane Asylum under their treatment and under ours, or compare Ward's Island Homœopathic Hospital reports with the reports of some of their own hospitals. Figures are what tell. The only symptom of the decline of homœopathy we are able to detect, after a careful examination, is the gradual adoption of our methods by the dignified "regulars" under the head of "NEW DISCOVERIES."

For some time past, and more especially during the past two years, the journals of the "regular" school have been replete with sketches, relating the discovery of facts which Hahnemann brought to light, and which for over a century have been applied by us in the practice of our profession. This re-discovering process, you will recall, is what Dr. Love calls "dignified ignoring."

There is a wonderful amount of originality in the Doctor's opinion, and we earnestly hope he will not follow his "regular" brethren in their unprincipled policy of "dignified ignoring" homœopathy, for our methods would certainly suffer in the hands of such an original genius. We sincerely regret that so much "dignified regular" talent should be thus needlessly expended in making these second-hand discoveries. Why don't you go and buy a Hughes, *Therapeutics*, or a Farrington's *Materia Medica*, and you will find enough discovered to keep you in wonder the remainder of your days. J. L. M.

After-Treatment of Cataract Operations.

DR. J. J. CHISHOLM, of the Presbyterian Eye and Ear Hospital of Baltimore, states his experience, in the *Southern Medical Record*, with strips of adhesive plaster to keep the eyes closed after operations for the removal of cataracts. He says in substance:

During the year, ninety-eight cataract extractions and sixty-nine iridectomies have been performed, with such a percentage of successes as warrants the statement that bandages and dark rooms are not only permanently abandoned at the hospital, but must in the very near future be given up by all ophthalmic surgeons.

During the course of this year's experiments, not only have light isinglass superseded the heavy compresses and bandages, but much of the restraint in universal use has been proved useless and arbitrary. Under the belief that when the two lids are made one by the adhesive strap, with the tarsal cartilages acting as splints over the corneal surface, and kept in position by means of the tonic contraction of the palpebral muscle, the eye recently operated upon was thoroughly protected from disturbances, regardless of the movements of the rest of the body, and many restraints in universal practice were one by one abandoned.

First, it was found not necessary to operate in the bed in which the patient was to remain during the after-treatment. For this was substituted an operating table of convenient height

and width, placed near a large window, from which good light could be had. This permits the operator to complete the manual to his own satisfaction. When the operation for cataract extraction is smoothly done, nine-tenths of the dangers against the restoration of sight are removed.

The next step in the abandoning of restraints was not to put the patients to bed, but to allow them the use of their limbs during the entire treatment. Dr. Michel, the advocate of the light room and light dressing treatment, still adopts the restraints in common use, not allowing his patients to turn from their backs for five days. When at the end of this period their backs were aching, he would allow them to turn over on the side opposite to the eye operated upon. I do not put them to bed at all. After the operation I allow them to use a lounge, bed, or chair, following their own preferences. They go to bed at their usual bedtime hour, sleeping on any side that it is most comfortable, and they dress themselves in the morning before breakfast.

For the past four months I have taken another great step forward, and have released the eye not operated upon from being strapped. This was a bold step in defiance of the theory universally accepted, that the movements of the eye, when left open, must affect the cornea of the other recently cut, and, therefore, a needful rest must be secured. However satisfying this theory may be—and we have all adopted it for generations back—the experience of the Presbyterian Eye and Ear Hospital, of Baltimore, has conclusively shown that this restraint was never called for and had never been of any utility, but, on the contrary, of much annoyance and discomfort.

Thus, one by one, the old rules of universal adoption have been abandoned, and I may say that now the revolution in the after-treatment of cataract cases has become complete.

Two noble Seniors held an animated discussion, recently, on the merits of the various young ladies of their acquaintance with regard to their abilities in a butter-making line.

Societies.

Hahnemannian Society.

THE second meeting of the Hahnemannian Society was held in the usual place November 9th; President Jewett in the chair.

Fourteen new members signed the constitution paid the initiation fee, and became members.

Roll call.

Minutes of the previous meeting read by secretary and accepted without amendment.

The President then introduced our new glee club, which received a hearty welcome.

Moriarty, '88, read a paper, reporting a case of skin disease, as treated by himself, with high potencies alone. Discussions by Hinman, Woodruff and Jackson.

Landauer favored the society with a banjo solo.

Jenkins, '89, read a paper reporting a case of confirmed opium habit, as witnessed by him, resulting in death, either from the drug or treatment. Remarks on same by Kastendeick, Moriarty and Hinman.

Declamation by Kastendeick. Balloting for quiz masters resulted in the re-election of the Seniors, except Baker being substituted for Hamlin in Practice. Middle and Junior quiz masters re-elected.

A committee consisting of the quiz masters were appointed to consider the matter of changing the hour of the Histology quiz.

Music by the Glee Club.

Reports of committees.

Library. Wilcox, '89, chairman, report accepted. Mr. Wilcox gave notice that at the next meeting an amendment to the by-laws would be offered.

Treasurer's report read and accepted. Banjo solo by Landauer.

Motion made by Hinman, second McGraw, that a committee be appointed to present a suitable expression of sympathy to the friends of Drs. G. M. Smith and B. F. Young, deceased.

The same to appear in THE CHIRONIAN. Committee—Hinman, Gwynn, Cummins, Jones, McGraw, Smith.

Motion made that the society furnish the

necessary funds to purchase books for the use of the Glee Club.

Music by Glee Club.

A vote of thanks to C. E. Low, '91, for his offer to furnish a piano for the meetings during the remainder of the session.

A motion made that the Faculty be requested to provide a gymnasium for the use of the students in the new college.

A vote of thanks for all who have contributed to the entertainment of the evening.

Roll call.

Adjournment.

IN MEMORIAM

A FEW days ago the sad intelligence reached the College that Professor G. W. Blodgett, of the class of '77, had passed away. For several years he suffered from phthisis, and thinking that a removal to a warmer climate would benefit his health, he went to Wilmington, N. C., where he was gladly welcomed by his friend and classmate, Dr. W. E. Storm. No improvement taking place, he returned to New York City and entered the Hahnemann Hospital as a private patient, where he died.

Shortly after Dr. Blodgett graduated, he was appointed on the staff of the Ward's Island Hospital, where he spent one year, was then appointed the first House physician to the Hahnemann Hospital. In 1881 he was requested by the Faculty of the New York Homœopathic Medical College to accept the chair of Physiology which he so ably filled for several years.

His ability to lecture to and teach the students was so well recognized by the Faculty, that he was also appointed to fill the chair of Lecturer on the Diseases of the Kidney.

In 1880 the late Dr. B. F. Joslin of this city extended an invitation to Dr. Blodgett to assume part of the former's practice, of which he availed himself, and upon the retirement of Dr. Joslin from active work, succeeded him.

Dr. Blodgett leaves behind him many friends who mourn for him and deplore the loss the profession has sustained by his death.

Notes from the Library

IT is the policy of the library to call attention to its needs on every occasion possible. Like any healthy infant, its wants are many, and no surer sign of weakness would be required than a lack of energy in making them known. The Committee would state that the subscription list is circulating in the Junior Class, and that they have already received the first installment, and have placed the amount to its credit. Backward subscribers from last year are also being looked after with good results.

Prof. Wright has lately given us two handsome volumes on *Hygiene and Public Health*, by Buck, besides several smaller works on the same subject. We have also to thank Messrs. A. L. Chatterton & Co. for a number of books, all of them valuable additions to the library. Frank has given us Volumes I. and II. of the CHIRONIAN, bound, and Prof. St. Clair Smith has again shown his interest by presenting numerous volumes of transactions, containing valuable papers. We are also indebted to Dr. J. C. Burgher for a copy of *Transactions of the American Institute of Homœopathy* for 1887.

An Unrecognized Cause of many Throat Ailments.

BY LENNOX BROWNE, F.R.C.S., LONDON, ENG.

PHILA. Co. Med. Soc. :—Extending the term *globus hystericus*, I find that, with hardly an exception, all and every other subjective sensation in the throat is symptomatic of an objective cause. The chief of such feelings are those of a heat, a prickling, a swelling, a weight, a straw, a hair, or other foreign body. A few patients—one especially, a hale farmer—have complained of a feeling of intense cold, which is sometimes relieved, sometimes aggravated, after food-taking. In some instances there is actual pain, with spasm, cramp, and a sensation of choking, and not infrequently there is cough; this symptom varies in degree from a slight hacking to the loud hyena-like bark known as nervous laryngeal cough. Many of

the cases of co-called laryngeal vertigo, or, as I prefer to call it, of laryngeal epileptiform seizures, are capable of explanation and cure on the lines I am at present taking.

The results of laryngoscopic investigations in my hands have shown that there is—

1. A varicose, and even truly hemorrhoidal condition of the veins at the base of the dorsum of the tongue, sometimes at the under surface and sides, in which last case it may be symptomatic of mitral insufficiency, or of severe hepatic derangement, or even of cerebral lesion. There is often a similar varicose state of the vessels in the superior surface of the epiglottis.

2. An enlargement of the circumvallate papillæ at the back of the tongue, causing the epiglottis to be hindered in its movements—imprisoned, as your President first called it.

Dryness of the Throat from Excessive Tea-drinking.

MR. PHILLIPS HILLS calls attention to this symptom, which, he says, is in himself the earliest and surest sign of excess in the use of tea. He says that some time ago, seeing a patient who was suffering from dry hacking cough, and sense of constriction in the larynx, he asked the physician in attendance whether the patient was an excessive tea-drinker, and was surprised to find the symptom was not generally known.—*Practitioner*, August, 1887.

A Practical and Successful Mode of Disinfecting the Room in Case of Cancer.

DR. H. GEROULD, of Cleveland, O., writes that from September, 1886, until March, 1887, he had in his house, and under his daily care, a patient with uterine cancer. To counteract the offensive odor of the disease he made repeated experiments with the prominent disinfectants. The following proved to be all he could desire, viz.: three drachms of potassium nitrate dissolved in eight ounces of Platt's chlorides, full strength. In this he saturated thin muslin (cheese cloth), then dried it thor-

oughly. When it was necessary to cleanse or purify the room, he burned small strips of the cloth on a shovel in different parts of the room and under the bed-clothing. The effect was magical. Almost instantly all offensive odors disappeared. This was repeated when necessary, the potassium nitrate being used to aid combustion. The result was such that no discomfort was experienced by the attendants, and no offensive odor could be detected in the adjoining rooms. This was daily remarked by friends. The undertaker said it was the first case of death from cancer where he could detect no trace of the disease. This method of disinfection, the writer adds, would be equally efficient in all contagious, pestilential or infectious diseases.—*New York Medical Journal*.

Pathology of Fatigue.

PROF. ANGELO MOSSO has for several years been studying the soldiers of the Italian army, with a view to understand the pathology of fatigue. He concludes that fatigue, when carried only to that point where the destructive process is normally balanced by the reconstructive, yields a sense of reinforcement, or even of exhilaration. When carried beyond this stage, fatigue sets up a process of decomposition in the blood by the infiltration into it of substances which have a toxic action, and which, injected into the veins of healthy animals, induce malaise and all the signs of excessive exhaustion. Prof. Mosso believes that the amount of "healthy fatigue" which an army can undergo can be calculated, and the amount of rest necessary regulated accordingly. He does not regard the modern Italian soldier as inferior to the ancient Roman, either in stature or in bodily power.—*New York Medical Abstract*.

MAUD: How gayly those little humming-birds flit from blossom to blossom, dipping their tiny bills in the dew-laden flowers.

TOM: Yes, just like the tailors.

MAUD: Like tailors?

TOM: Their little bills all over due, you know.—*Harvard Lampoon*.

College Notes.

WHO is Hogan?

Who is the greatest Martino "of the middle Class"?

A CERTAIN middleman who talks in his sleep, is said to make use of the following phrase most frequently: "A half more."

" 'Tis better late than never." Thus would we welcome the dilatory middlemen who have been unable to meet with us before.

H. A. WHITMARSH, of East Providence, R. I., a member of Class of '79, is combining business with pleasure by attending the Post-graduate school.

THE man who will put his name to a subscription, and then without a good reason not only refuse to pay up, but consign to perdition the object of the subscription, presents an anomaly hard to understand.

At the surgical clinic on Wednesday, December 7th, the CHIRONIAN was gratified to see our friend Denison of '89. We are sorry that '89 is to lose him, but his desire to graduate from the New College has too much hold upon him.

THE class had an opportunity, recently, of seeing another of Dr. Wilcox's ingenious devices. It being a brace for the thigh and leg, so constructed that the leg could be flexed or extended, by a joint or hinge opposite the knee, protected by a spring.

MIDDLEMAN (to obsequious Freshman at Dr. Helmuth's operation at Ward's Island Hospital): Say! I wonder if that is the sagittal or lambdoidal suture that the Doctor is using?

Freshman (after brief cogitation and with a consequential air): Guess that it is the lambdoidal.

At the last annual meeting of the Society for Medico-Scientific Investigation, the following officers were elected: President, W. W. Blackman, '77; Vice-President, C. Dedy, '76; Secretary, E. J. Pratt, '81; Treasurer, C. S. Macy, '81; Librarian, M. Leal, '79. Executive Committee: A. B. Norton, '81, W. E. Rounds, '74, S. H. Knight, '86.

OVERHEARD in the corridor of college Student (just returned from the dissecting room to friend): Say! there is a fine subject down there not much more than a skeleton! Scarcely any flesh on it. It is terribly *emancipated*.

P. S. The body referred to was that of a colored person, but the student is not supposed to have referred in any way to Abe Lincoln's famous proclamation.

At the last meeting of the Homœopathic Medical Society of the county of New York, held at the Ophthalmic Hospital, on December 8th, the following officers were elected: President, J. M. Schley; Vice-President, B. G. Clark; Secretary, A. B. Norton; Treasurer, S. H. Vehslage; Librarian, Charles McDowell; Censors, S. T. Wilcox, F. E. Doughty, L. L. Danforth, H. M. Dearborn, Malcolm Leal.

THE appearance of Professor St. Clair Smith last Saturday morning, in the medical clinic, just added to the Senior course, was the signal for enthusiastic applause on the part of the students. Technical knowledge on the part of the student of medicine is comparatively valueless unless it has added to it clinical experience. Especially is this so in the Department of Practice, and we are very glad to see that the Faculty so readily granted the request of the students to establish this new feature of the course; and we are especially pleased to see Professor Smith fill the chair.

THE December *Century* is undoubtedly one of the finest numbers ever issued of this incomparable magazine. It begins with a frontispiece portrait of Lincoln, and contains an account of his journey through Baltimore to Washington for inauguration. These historical papers should be familiar to every citizen, man, woman and child, as being the most impartial review of the important events of that time. In *Prison Life of the Russian Revolutionist*, by George Kennan, we are told why so many of the subjects of the Czar try assassination as a relief from their civil troubles. *Au Large*, by Cable, is continued. Altogether, it is a holiday indispensable, and never fails to gratify.